What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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ONE BRICK AT A TIME

The concept of building Community Health Compounds (CHC) is often misunderstood. District Health Management Teams (DHMT) planning for the CHPS programme see the CHC as something that costs money, and therefore something that must wait for funds to arrive. Communities in the CHFP demonstrate another approach: Begin by starting with whatever resources are available to build a CHC that is constructed with local material, maintained with community labour, and supported by a broad consensus that health care cannot wait. Then, from the position of achievement and success, utilize the functioning CHC as a magnet for acquiring funds for putting up a better structure where health can be adequately housed. In short, build the primary health care programme one brick at a time. This approach is demonstrated by two Navrongo Project communities, Kayoro and Naga which built and maintained their own compounds to house the resident nurse in 1994. The buildings that were constructed are not a model for others to emulate: Torrential rains in the course of the first year collapsed exterior walls of both of these CHC, leaving them in a very bad state. But, in 1995 District resources were found to renovate the CHC with iron sheet roofs, cement floors, and simple amenities, such as a latrine. These very simple CHC functioned for the next six years. By 2002, they were once again on the brink of collapse, rendering them uninhabitable. The disruption threatened to derail health service delivery. As a result of the importance of these CHC, efforts were quickly mobilised to get them functioning again. While CHC have been a continuing source of maintainance problems since 1994, communities have received continuing doorstep health care from the Community Health Officers who worked out of the CHC. The experience of Naga and Kayoro shows that the 'one brick at a time' approach to developing adequate CHC can revolutionize access to health care.

The original Kayoro community-donated CHC

Today, in Naga and in Kayoro, new and modern CHCs are under construction, owing to modest external funds that have been acquired to supplement community resources. The success of the Naga and Kayoro community-donated and -financed CHC has been used to seek funds for rewarding community action and initiative. Some features of the new CHC are informed by past success:

- *Location.* It is no coincidence that, in both communities the new CHC is less than 200 meters away from the old one. Community involvement in site selection produced locations that differ little from community selected sites for the original CHC.
- *Community involvement.* Building community involvement was crucial to building the CHC. This involved getting initial practical demonstration of commitment that in spite of the approach of the farming season, people can be mobilised for construction work.

Digging the foundation under the Supervision of the Chief and people

- *Community innovation and initiative.* It is important not to standardize the construction programme. CHC construction does not involve contractors or rigid Ghana Health Service instructions. This is important for maintaining community commitment and initiative. For example, the western part of the district is generally rocky, and stone is not readily available in Kayoro especially around the area earmarked for the CHC. The chief devised a strategy of breaking the people into groups to work by sections. Division of labour was working to perfection at the community level. Where stone is available, that section concentrated on collecting stone while other sections gathered sand. Women and children supplied water. The District Assembly, the highest political authority in the district, kept their part of the deal by providing a truck and a driver to cart the sand to the building site. They also provided an engineer and a mason to train community volunteers. The project offered building tools such as moulds, shovels, pick axes, trowels and head pans and the community members gave what they have in abundance—labour. Sometimes there were more people at site ready to work than there were tools to work with! This has been particularly the case with the Kayoro project. Then, one brick at a time, the Kayoro project was soon to overtake the Naga CHC which started one month earlier.

Women are often prepared to risk their health to get a CHC constructed

- *Community support for the service system.* The CHC is a crucial component of the CHFP service delivery model. Once Community Health Officers are retrained, equipped and redeployed, they need a place to live and work. One element that is often taken for granted is patronage of the services for which the CHC is constructed. People must not only be passionate about helping the nurse relocate and integrate into the community but they must, above all, patronize the services brought to their doorstep.

Two headpans are better than one—Mason provided by the District Assembly casting the foundation concrete

What is worth noting about the Naga and Kayoro CHC construction approach is that they started the programme with their own resources, then a better CHC was constructed with project resources such as a District Health Management Team can afford. It is the success in implementing the programme that attracted external resources for building a CHC component of the programme that works, one brick at a time.

Send questions or comments to: What works? What fails?
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